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January 26, 2005

DEPARTMENT OF ENERGY
OFFICE OF HEARINGS AND APPEALS

Hearing Officer's Decision

Name of Case: **Personnel Security Hearing**

Date of Filing: **July 22, 2004**

Case Number: **TSO-0130**

This Decision considers the eligibility of XXXXXXX XXXXXXX (hereinafter referred to as "the individual") to hold an access authorization under the regulations set forth at 10 C.F.R. Part 710, entitled "Criteria and Procedures for Determining Eligibility for Access to Classified Matter or Special Nuclear Material." As explained below, it is my decision that the individual's access authorization should not be restored.

I. *BACKGROUND*

The individual is an employee of a Department of Energy (DOE) contractor. In 2001, the individual was granted a DOE access authorization. An incident report received by the DOE in August 2002 indicated that the individual was hospitalized for psychiatric care. The DOE conducted a personnel security interview with the individual in September 2002 (the 2002 PSI). The individual was hospitalized again in December 2002 for psychiatric care. In February 2003, a DOE-consultant Psychiatrist conducted a psychiatric evaluation of the individual. The DOE conducted a second personnel security interview with the individual in April 2003 (the 2003 PSI).

In December 2003, the Manager for Personnel Security of the DOE area office where the individual is employed (the Manager) issued a Notification Letter to the individual. The Notification Letter states that the individual has raised a security concern under Sections 710.8(h) of the regulations governing eligibility for access to classified material. With respect to Criterion (h), the Notification Letter finds that the individual was evaluated by the DOE-consultant Psychiatrist in February 2003, and it is the DOE-

consultant Psychiatrist's opinion that the individual suffers from "Bipolar Disorder, Most Recent Episode Manic, Severe with Psychotic Features, In Remission." The Notification letter states that the DOE-consultant Psychiatrist concluded in his evaluation that the individual has an illness or mental condition of a nature which causes, or may cause, a significant defect in his judgment or reliability. Specifically, he found that the individual's signs and symptoms were compatible with the DSM-IV-TR diagnosis of Bipolar Disorder, Type I, Mixed.

The Notification Letter also states that during the 2002 PSI, the individual admitted to treatment and hospitalization with regard to his mental/emotional state in July 2002 when he was diagnosed with a bipolar condition and placed on medication for that condition. It further states that the individual indicated that he was treated for depression in 1995 or 1996 due to job loss and family stress, and that he was treated in 1985 or 1986 for stress. Finally, the Notification Letter states that medical records indicate that in July 2002, the individual's treating physician (the initial treating physician) diagnosed him with "Axis I: Bipolar disorder versus psychosis not otherwise specified and Axis II: Personality disorder not otherwise specified."

The individual requested a hearing to respond to the security concerns raised in the Notification Letter. In his response to the Notification Letter and in subsequent filings, the individual contested the DOE-consultant Psychiatrist's conclusion that the individual has a mental condition that causes or may cause a significant defect in his judgment and reliability. He asserts that recent medical records indicate that he has no current psychiatric symptoms, and that his course of treatment has been effective. The hearing was convened in October 2004 (hereinafter the "Hearing"), and the testimony focused on the concerns raised by the DOE-consultant Psychiatrist's diagnosis and the individual's efforts to mitigate those concerns.

II. *REGULATORY STANDARD*

In order to frame my analysis, I believe that it will be useful to discuss briefly the respective requirements imposed by 10 C.F.R. Part 710 upon the individual and the Hearing Officer. As discussed below, Part 710 clearly places upon the individual the responsibility to bring forth persuasive evidence concerning his eligibility for access authorization, and requires the Hearing Officer to base all findings relevant to this eligibility upon a

convincing level of evidence. 10 C.F.R. §§ 710.21(b)(6) and 710.27(b), (c) and (d).

A. *The Individual's Burden of Proof*

It is important to bear in mind that a DOE administrative review proceeding under this Part is not a criminal matter, where the government would have the burden of proving the defendant guilty beyond a reasonable doubt. The standard in this proceeding places the burden of proof on the individual. It is designed to protect national security interests. The hearing is "for the purpose of affording the individual an opportunity of supporting his eligibility for access authorization." 10 C.F.R. § 710.21(b)(6). The individual must come forward at the hearing with evidence to convince the DOE that restoring his access authorization "would not endanger the common defense and security and would be clearly consistent with the national interest." 10 C.F.R. § 710.27(d). *Personnel Security Review (Case No. VSA-0087)*, 26 DOE ¶ 83,001 (1996); *Personnel Security Hearing (Case No. VSO-0061)*, 25 DOE ¶ 82,791 (1996), *aff'd*, *Personnel Security Review (VSA-0061)*, 25 DOE ¶ 83,015 (1996). The individual therefore is afforded a full opportunity to present evidence supporting his eligibility for an access authorization. The regulations at Part 710 are drafted so as to permit the introduction of a very broad range of evidence at personnel security hearings. Even appropriate hearsay evidence may be admitted. 10 C.F.R. § 710.26(h). Thus, by regulation and through our own case law, an individual is afforded the utmost latitude in the presentation of evidence which could mitigate security concerns.

Nevertheless, the evidentiary burden for the individual is not an easy one to sustain. The regulatory standard implies that there is a presumption against granting or restoring a security clearance. *See Department of Navy v. Egan*, 484 U.S. 518, 531 (1988) ("clearly consistent with the national interest" standard for the granting of security clearances indicates "that security determinations should err, if they must, on the side of denials"); *Dorfmont v. Brown*, 913 F.2d 1399, 1403 (9th Cir. 1990), *cert. denied*, 499 U.S. 905 (1991) (strong presumption against the issuance of a security clearance). Consequently, it is necessary and appropriate to place the burden of persuasion on the individual in cases involving national security issues. In addition to his own testimony, we generally expect the individual in these cases to bring forward witness testimony and/or other evidence which, taken together, is sufficient to persuade the Hearing Officer that restoring access authorization is clearly consistent with the national interest.

Personnel Security Hearing (Case No. VSO-0002), 24 DOE ¶ 82,752 (1995); *Personnel Security Hearing (Case No. VSO-0038)*, 25 DOE ¶ 82,769 (1995) (individual failed to meet his burden of coming forward with evidence to show that he was rehabilitated and reformed from alcohol dependence).

B. *Basis for the Hearing Officer's Decision*

In personnel security cases under Part 710, it is my role as the Hearing Officer to issue a decision as to whether granting an access authorization would not endanger the common defense and security and would be clearly consistent with the national interest. 10 C.F.R. § 710.27(a). Part 710 generally provides that "[t]he decision as to access authorization is a comprehensive, common-sense judgment, made after consideration of all relevant information, favorable and unfavorable, as to whether the granting or continuation of access authorization will not endanger the common defense and security and is clearly consistent with the national interest." 10 C.F.R. § 710.7(a). I must examine the evidence in light of these requirements, and assess the credibility and demeanor of the witnesses who gave testimony at the hearing.

III. *HEARING TESTIMONY*

At the Hearing, testimony was received from three persons. The DOE presented the testimony of the DOE-consultant psychiatrist. 1/ The individual testified and presented the testimony of his son.

A. *The DOE-consultant Psychiatrist's Initial Testimony*

The DOE-consultant Psychiatrist testified that his diagnosis and concerns were based on the individual's record of four hospitalizations for mental problems in recent years. He stated that these hospitalizations had reasonably consistent symptoms, and that the diagnosis of bipolar disorder had been made on at least one of these hospitalizations. He added that the record of these hospitalizations and the individual's description of them at the PSI's, indicated that he was quite ill and "out of touch with reality, psychotic." Transcript of Hearing (TR) at 10. He

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1/ As indicated by the resume and testimony of the DOE-consultant psychiatrist (TR at 8-9), he has extensive clinical experience in diagnosing and treating mental illnesses. He clearly qualifies as an expert witness in this area.

testified that the increasing frequency of these hospitalizations confirmed his belief that the individual suffered from bipolar disorder.

> Let me mention that my interview sustained my impressions from reviewing the security file, and basically there were four hospitalizations beginning in 1985, then 12 years later, in 1997, then only five years later, in 2002, July, and then six months later, in December of 2002. This is rather classic of this disorder, bipolar disorder, where if inadequately treated, the episodes come quicker.

TR at 11. The DOE-consultant Psychiatrist also stated that the individual's statements to the DOE and at his psychiatric interview indicated his failure to acknowledge that he had bipolar disorder.

> [The individual], I felt was not entirely convinced that he suffered from bipolar disorder. He said in his most recent personnel security interview, and in my interview, that one of the two 2002 episodes was caused by withdrawal from nicotine, that he missed a cigarette break and that precipitated a reaction that was referred to by the physician as mania, [the individual] said or thought. And I believe [the individual] felt that honestly, that it was due to not having that nicotine. On a precious episode [the individual] felt that there was a possibility of one of the prescription medications you were given might have precipitated an episode. So I felt [as] if [the individual] did not embrace his condition of bipolar disorder, which I feel that he does suffer from.

TR at 11-12. In this regard the DOE-consultant Psychiatrist noted that due to the cyclic nature of bipolar disorder, it was difficult for the individual to acknowledge his condition, even though his changes in behavior had been extreme.

> And again, this is rather typical of this disorder, that patients that have it tend not to come to grips with it. And this is because of the cyclic nature of this disorder. The vast majority of the time, depending on the severity of the disorder, the individual may be just fine, may be a loving and successful family person and employee. But when an episode comes on, then there is a striking and marked change in behavior, that is

> demonstrated by some of the dialogue from the security interviews and my interview, and with some of his behavior during the peak of one of these episodes, I recall dashing out of a restaurant and feeling a need to knock on neighborhood doors, asking for residents to call 911. The police arrived and they used cuffs to bring you to the hospital.

TR at 12. The DOE-consultant Psychiatrist stated that he had conducted a series of psychological tests on the individual, including a personality inventory and a depression scale. He said that these tests were normal because when he interviewed the individual, he was in full remission and the tests reflected his current state of mind. He emphasized that the core of his impression that the individual had bipolar disorder was based on the individual medical history and the descriptions of symptoms provided by the individual. TR at 13.

When asked to assess the individual's probability of relapse, the DOE-consultant Psychiatrist stated that individual's history of bipolar episodes indicated that he will have additional episodes in the future.

> And the life history of this disease is known. And the life history would say that it is lifelong comparable to, say, diabetes, it doesn't go away. It just goes into a remission. And after four episodes that required hospitalization, in my opinion, the odds are that there is a likelihood that there will be another.

TR at 14. The DOE-consultant Psychiatrist also found that the medications being taken by the individual were not adequate to prevent future bipolar episodes.

> First, the correct medication certainly does help prevent and make milder subsequent episodes, but it does not eliminate the chance. But the other problem is that the medications I saw that [the individual] was taking, were not the appropriate medications. . . .
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> For this disorder, bipolar disorders, one needs to be on one or more mood stabilizing medications. And when there is Bipolar Type I mania, full-blown mania, that can be severe with psychotic features, many in the field would say that antidepressants are contraindicated, or certainly should be used only in the depths of

> depression. And as I recall, [the individual] was taking an antidepressant, Wellbutrin, and an antipsychotic agent, Risperdal, and was not on a first-line mood stabilizing medication, though certainly the company that makes Risperdal has attempted to advertise it as a mood stabilizing agent. It's a second-tier agent, in my opinion, and not a first line.

TR at 15. The DOE-consultant Psychiatrist added that even if the individual were taking the best available medications, a significant risk of his having future bipolar episodes would still exist.

> Taking the medication doesn't change the condition. It doesn't cure it. . . . [O]nce someone has bipolar disorder, the best analogy is diabetes, you treat it, but you don't cure it.

TR at 15-16. He indicated that a finding that the individual had minimized the risk of a future episode would require several factors, including proper medication and "rather frequent" medical follow-up, due to the severity of the individual's bipolar condition. TR at 16. He also stated that the individual would have to acknowledge his bipolar condition in order to learn more about his condition and to guard against future episodes. TR at 17.

In response to questions from the individual's counsel, the DOE-consultant Psychiatrist testified that the psychological tests that he performed on the individual 2/ revealed no psychological symptoms or problems, but that he did not believe that these tests indicated a favorable prognosis for addressing future mental problems. He repeated his opinion that the tests measured the individual's mental condition on the day that he took the tests, and could not assess the likelihood or severity of future episodes of bipolar behavior. TR at 25.

The DOE-consultant Psychiatrist stated that the pattern of increasing frequency of episodes evidenced by the individual's history indicated that he was likely to have bipolar episodes on a

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2/ The five tests administered to the individual by the DOE-consultant Psychiatrist were Done's Depression, Gill-Brown Obsessive OCD, Mini Patient Health Survey, Hamilton Anxiety Rating, and Personality Assessment Inventory.

yearly basis. TR at 30. However, he stated that if the individual showed that he has been asymptomatic for twenty-two months since his December 2003 episode, it would not necessarily indicate that his diagnosis of bipolar disorder was incorrect or that the individual's current medications are effectively preventing bipolar episodes. TR at 31-37.

With respect to mitigating the risk of future episodes, the DOE-consultant Psychiatrist emphasized that it is not enough that the individual understand that he has some sort of mental condition that he must be careful about. Rather, the DOE-consultant Psychiatrist stated that it was necessary for the individual to acknowledge his bipolar condition and learn about it. TR at 42-43. He believes that the individual's type of bipolar disorder is rare and more treatment resistant because the depression and mania symptoms are mixed together.

> Bipolar is made up of manic episodes with or without depressive episodes. So one can have depression at one point and then mania at another point, or they may just have episodes of mania. In [the individual's] case, the mania and depression get mixed together. So I believe he's got a subtype that's called Bipolar Type I mixed. In other words, there are symptoms of mania and depression that coexist. It's rare, it's more treatment resistant.

TR at 50-51.

B. *The Individual's Son*

The Individual's Son testified that he is in his mid-twenties and has resided with his father "off and on" for four or five years, and that he has resided exclusively with his father for the last year. TR at 53-54. At the time of his father's July 2002 episode, he was not living with his father. TR at 54. Nevertheless, he indicated that his father had been exhibiting manic behavior throughout the week prior to his arrest and hospitalization. TR at 57. The day of the arrest, he and his sister met their father at a restaurant and suggested that he get medical help for his mental symptoms. TR at 56.

The individual's son added that his father had been exhibiting manic behavior throughout the week prior to this episode. In 2003, following his father's release from the veterans hospital, the son moved in with his father. He testified that his father's medical

condition has improved "dramatically" since 2002, and that he is now able to get through the normal stresses of life a lot better than before. TR at 59. He stated that he is aware that his father is taking medication, but did not know what it was. He stated that, other than July 2002, he has not observed his father having any episodes of manic behavior. TR at 61. He also has not observed his father having "a bout of depression" since 2002. TR at 67-68.

C. *The Individual*

In his response to the Notification Letter, the individual challenged the DOE-consultant Psychiatrist's conclusion that his mental condition causes or may cause a significant defect in his future judgment and reliability.

> [The individual] contends that [the DOE-consultant Psychiatrist's] opinion is erroneous and should not be given the same weight as his own treating physician. [The individual's] recent medical records indicate that no current problems exist with regard to his condition and that his course of treatment has been effective. Further, [the individual] has experienced no hospitalizations for his condition since December of 2002, a period of nearly two years. This fact runs contrary to [the DOE-consultant Psychiatrist's] findings and is probably the single best evidence that no significant defect exists.

Individual's September 15, 2004 "Initial Response to Agency's Decision Letter" at 2.

In his testimony at the Hearing, the individual testified that he completed two tours of duty in Vietnam during that conflict, and that he had worked at a battalion aid station in Vietnam and assisted with casualties. He stated that what he witnessed was difficult for him to see and experience, and that it has affected him increasingly in recent years. TR at 72. He stated that during his most recent hospitalization in December 2003 at a veterans hospital, he was diagnosed by his treating physician (the veterans hospital doctor) as suffering from post-traumatic stress disorder and depression. He testified that he was continuing to take the two medications, Wellbutrin and Risperdal, that were prescribed for him by this doctor. TR at 74.

The individual testified that in 1985 he was hospitalized for depression which was caused by his divorce. He stated that in 1997 he was hospitalized with major depression and took medications for depression for about two years. He said that he discontinued the medications and counseling because he had a problem getting to see the doctor. TR at 76.

With respect to his July 2002 hospitalization, he testified that he was having problems with his son who had been arrested for possession of marijuana. He also noted that his father had had surgery in February of 2002. TR at 77. He stated that he had attempted to admit himself to a hospital the day before the incident involving the police because he was having trouble sleeping and felt that he needed medications. He stated that he failed to gain admittance to that hospital because his insurance would not pay for it. He stated that the following day, the police gave him a ride to another hospital where he was admitted. TR at 79-80.

The individual testified that during his July 2002 hospitalization he was prescribed Wellbutrin, and continued to take it. However, in December he admitted himself to a veterans hospital. He stated that he was still experiencing stress concerning his son, and that he also experienced the death of an aunt in August 2002 and a cousin in November 2002. TR at 81. He stated that he was having trouble sleeping and felt that he needed more help than just the medication that he was taking. TR at 82. He stated that both the July and December 2002 hospitalizations were preceded by depression, flashbacks, and sleep problems.

> Well, I was having flashbacks of Vietnam, and I was having trouble sleeping. And by trouble sleeping, I mean I'd go days without being able to sleep, and then when I did sleep, I would only sleep an hour or two. . . . I would cry a lot, and would have problems stopping crying.

TR at 87.

The individual testified that during his December 2002 hospitalization, which lasted 12 to 13 days, he had classes on depression, counseling, and group sessions. He stated his treatment was more effective than his July 2002 hospitalization because he gained a greater understanding of what was happening to him. He stated that he was able to discuss the problems that he was having with memories of Vietnam and having flashbacks, and was

able to spend more time with his doctors. He stated that they added Risperdal to his medications at that time. TR at 82-83.

The individual testified that following the December 2002 hospitalization, he immediately returned to work and has not been hospitalized since then. He stated that he sees the veterans hospital doctor now about once every six months.

> She felt that I was doing so well that that's all I needed to have a scheduled appointment with her. I always can call and get an emergency appointment if I felt I needed it, but I haven't felt that I needed it.

TR at 85. He testified that he has had no episodes of extreme behavior since July 2002. TR at 86. He stated that he has had no sleep problems in the past twenty-two months. TR at 88-89.

When questioned by the DOE Counsel, the individual testified that he suffered from depression and post traumatic stress disorder. He stated that the doctors who had been treating him since December 2002 through the veterans hospital had given him that diagnosis. He stated that he disagreed with the diagnosis of bipolar disorder given to him by the DOE-consultant Psychiatrist and by the doctor who treated him during his July 2002 hospitalization. TR at 98-99. He stated that if he started to experience any symptoms of his condition, he would contact the veterans hospital doctor for an emergency appointment. TR at 103.

D. *The DOE-consultant Psychiatrist's Second Appearance*

After hearing the testimony of the individual's son and the individual at the Hearing, the DOE-consultant Psychiatrist was asked to comment concerning what he had heard. He stated that:

> I think it's a very good sign that there have been no subsequent episodes of depression or mania despite what I consider incorrect medication, and apparently a lack of a diagnosis of bipolar disorder. I feel that the longer [the individual] goes without a further episode, the better. I do not think that the current medication regimen is ideal, given that I'm correct on this diagnosis, which I feel confident in.

TR at 109. He stated that the individual's treatment would be ideal for a major depressive episode but not where the individual has experienced a manic episode. He noted that in about fifteen

percent of cases of bipolar disorder, the use of antidepressants can flip the patient into a manic episode. TR at 110.

With regard to the veterans hospital doctor's diagnosis, he stated that the symptoms of post traumatic stress disorder (PTSD) involved startled reactions to sudden noises and a general flattening of the patient's affect, and that the symptoms do not overlap with the type of manic behavior that was exhibited by the individual in July 2002. TR at 111. When asked about the individual's prognosis for a future bipolar episode, the DOE-consultant Psychiatrist stated that the possibility was less than it was when he examined the individual in February 2003, but he believes that there is a risk for a future episode. TR at 115. He declined to endorse the individual's continuing contact with the veterans hospital doctor as a sufficient medical safeguard to mitigate this risk.

IV. *POST-HEARING SUBMISSIONS*

At the Hearing, the individual's counsel was unable to present the testimony of the veterans hospital doctor, and the Hearing was adjourned pending the convening of a telephone conference where her testimony would be presented. In a letter dated November 15, 2004, the individual's counsel stated that his repeated attempts to get the veterans hospital doctor to testify concerning her treatment of the individual had not been successful. He requested a continuance of the individual's hearing until mid-December 2004 so that he could present the testimony of an another medical expert. He also submitted medical records concerning the individual that he obtained from the veterans hospital.

In a letter to the parties dated November 16, 2004, I rejected the request for a further continuance of the Hearing. However, I held open the record of the proceeding until December 15, 2004 in order to permit the submission of additional affidavits and other evidence concerning the individual's medical condition. In that letter, I encouraged the DOE-consultant Psychiatrist to comment on the individual's veterans hospital medical records and on the diagnosis of the veterans hospital doctor contained on those records. I also suggested information that the individual could submit that would assist in mitigating the DOE's concerns. I noted that the veterans hospital records did not extend past February 2002 and suggested that any more recent medical records of the individual also should be submitted. I encouraged the individual to submit an additional psychiatric evaluation if he believed that such evidence would help to mitigate the DOE's concerns. Finally, I repeated what I stated a number of times during this proceeding

that it is essential that the individual provide evidence from knowledgeable witnesses to corroborate his assertion that he has had no episodes of mental illness since December 2002. I suggested that more recent medical records and letters from his treating physicians and close relatives would help to provide this corroboration. November 16, 2004 Letter from Hearing Officer to the parties, Case No. TSO-0130, at 1-2.

On December 15, 2004, the individual submitted an affidavit from a psychiatrist (the Evaluating Psychiatrist) who examined him on two occasions earlier in the month. 3/ In his affidavit, the Evaluating Psychiatrist states that he is aware of the DOE's security concerns about the individual. He also states that he has reviewed the individual's prior medical records, particularly those of the veterans hospital concerning the individual's December 2002 hospitalization. He states that based on his time with the individual, he has arrived at a diagnosis of (1) major Depression with psychotic features, recurrent; (2) post traumatic stress disorder; and (3) combat trauma. He states that his diagnosis "mirrors the diagnosis" of the individual's treating physicians at the veterans hospital, and further states that he "did not find any indication that [the individual] suffers from bi-polar disorder." Evaluating Psychiatrist Affidavit at 2-3. However, he finds that even if the individual did suffer from bi-polar disorder, his current medications would not be inappropriate. He believes that the individual's hospitalization in December 2002 was due to the medication he was taking at the time.

The Evaluating Psychiatrist states that it is certainly likely that the individual will suffer from a depressive episode again sometime during his life. However, he believes that this episode will not be significant for several reasons.

> First, he has gone approximately two years without a new episode. This indicates that his medications are working, that he is compliant with them and that his condition is under control. Second, while under treatment any episode would be muted in its severity. Additionally, an episode would develop more slowly than his previous episodes. These factors would allow for

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3/ The affidavit indicates that the Evaluating Psychiatrist is board certified and has considerable professional experience in a hospital setting. I conclude that he qualifies as an expert witness in this area.

> early detection and treatment and greatly minimize the frequency and severity of any future episodes. . . .
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> Based upon my time with [the individual], it is clear to me that he understands the nature and severity of his condition and the need for ongoing treatment. Additionally, he is able to identify the warning signs of an episode, allowing him to seek additional treatment.

Evaluating Psychiatrist Affidavit at 3-4. He concludes that the individual's medical condition should not cause a significant defect in judgment or reliability. Id. at 4.

A copy of the Evaluating Psychiatrist's affidavit was sent to the DOE-consultant Psychiatrist. In comments received by this Office on January 18, 2005, the DOE-consultant Psychiatrist stated that he believed that there was sufficient medical evidence to support the diagnosis made by himself and by the individual's doctor during his July 2002 hospitalization that the individual suffers from bipolar disorder. He therefore declined to make any changes in his findings and in his recommendations for treatment.

V. *ANALYSIS*

Through his counsel and in his testimony at the Hearing, the individual presented four arguments for the purpose of mitigating the security concern. The first is an assertion that the DOE-consultant Psychiatrist did not have a sufficient basis for his diagnosis of "Bipolar Disorder, Type I, Mixed" and that the diagnosis is therefore erroneous. Rather, he asserts that he suffers from (1) major depression with psychotic features, recurrent; (2) post traumatic stress disorder; and (3) combat trauma. The second contention is that the individual has acted in accordance with the guidance of his doctors and is now taking medications that are appropriate for treating his condition. The third contention is that he has not had a psychotic or manic episode since July 2002. Finally, he contends that his ongoing regimen of medication, his semi-annual consultations with the veterans hospital doctor, his skills at identifying an oncoming depressive episode, and his access to emergency treatment are sufficient to cope with any future episode of unusual behavior. For the reasons stated below, I conclude that the arguments and evidence presented by the individual do not resolve the security concern.

A. *Alleged Errors in the DOE-consultant Psychiatrist's Diagnosis of Bipolar Disorder*

In his Response to the Notification Letter and in his Hearing testimony, the individual argues that the DOE-consultant Psychiatrist did not have a sufficient basis for arriving at his diagnosis of bipolar disorder. I do not agree. The individual does not dispute that he has incurred four inpatient hospitalizations since 1985, with the last two occurring in July and December 2002. The individual's medical record indicates that in July 2002 he had been brought to the hospital by the police when he became agitated at a restaurant, cursed the waitresses, and ran through the neighborhood knocking on doors and causing disturbances. Also, it indicates that he had a history of hallucinations and paranoid thought processes. *See* Psychiatric Assessment of Attending Physician dated July 26, 2002 at DOE Exhibits, Tab 2, Exhibit 3. This attending physician diagnosed the individual with bipolar disorder and psychosis. *Id.* at 2. The medical record further indicates that during his July 2002 hospitalization, the individual became angry on the psychiatric unit and had to be restrained. *See* Clinical Documentation Note dated July 30, 2002, at DOE Exhibits, Tab 2, Exhibit 3.

The DOE-consultant Psychiatrist acknowledged that the individual may also suffer from post traumatic stress disorder, but stated that that condition alone would not account for all of his symptoms. It is not clear that the veterans hospital doctors were aware of the individual's July 2002 behavior when they issued a diagnosis during his December 2002 hospitalization that did not include bipolar disorder. Finally, I am not convinced by the statement of the individual's Evaluating Psychiatrist that he found "no indication" that the individual suffers from bipolar disorder. The DOE-consultant Psychiatrist's testimony at the Hearing indicates that individuals exhibit no symptoms or indications of bipolar disorder except during an episode. Although the Evaluating Psychiatrist states that he reviewed the individual's prior medical records, he only refers specifically to the records of the individual's December 2002 hospitalization at the veterans hospital. His affidavit contains no mention of the manic behavior exhibited by the individual prior to and during his July hospitalization, or to the diagnosis of bipolar disorder made by the attending physician during that hospitalization. 4/

4/ The individual's counsel notes that the veterans hospital

(continued...)

Accordingly, I find that the evidence in the record supports the DOE-consultant Psychiatrist's diagnosis of bipolar disorder. I therefore find that the DOE properly invoked Criterion (h) in suspending the individual's access authorization.

B. *The Effectiveness of the Individual's Current Medication*

The individual testified that he is following the advice of the veterans hospital doctor in taking Wellbutrin and Risperdal to treat his ongoing mental condition. He asserts that this regimen has protected him from experiencing any depressive and/or manic episodes since December 2002. In his comments at the hearing, the DOE-consultant Psychiatrist states that the individual's medicines are not adequate to prevent future bipolar episodes. He states that in about fifteen percent of bipolar patients who are given an antidepressant, the effect of the antidepressant is to "flip" them into a manic episode. He also states that he does not consider Risperdal to be a "first-line mood stabilizing medication," although he acknowledges that the manufacturers of Risperdal have attempted to advertise it as a mood stabilizing agent. In his affidavit, the Evaluating Psychiatrist states that the combination of Wellbutrin and Risperdal is effective for treating bipolar disorder. He notes that Risperdal may be used as a mood stabilizer and has been approved by the Federal Drug Administration for the treatment of bipolar disorder, among other uses.

I find considerable merit in the individual's argument that the effectiveness of his medical regimen of Wellbutrin and Risperdal would be demonstrated by a showing that he has not had a depressive and/or manic episode in the period of almost two years since he began taking the drugs. If this assertion of almost two years without medical symptoms was supported by sufficient evidence, I would find that his medicines are currently effective in preventing his symptoms. However, as discussed below, I do not believe that the individual has corroborated his assertion that he has been free of symptoms since his December 2002 hospitalization.

4/(...continued)
doctor attributes the individual's December 2002 symptoms chiefly to a reaction to his medication, and that the Evaluating Psychiatrist accepts this finding. However, I do not know if they would have reached this conclusion if they had been aware of the symptoms and behavior that the individual exhibited prior to and during his July 2002 hospitalization.

C. *Evidence Concerning the Individual's Alleged Absence of Symptoms Since 2002*

The individual contends that he has not had a psychotic or manic episode since July 2002 and that he has not had a depressive episode since December 2002. At the telephone conference call convened in this proceeding on October 14, 2004, I told the individual's counsel that in order to the individual to substantiate his assertion that he has been free of symptoms since 2002, he needs to present sufficient corroborative evidence from knowledgeable witnesses. I repeated this advice at the outset of the Hearing. TR at 5. Nevertheless, at the Hearing the individual presented only his testimony and the testimony of his son concerning the absence of depressive and/or manic episodes since 2002. While I find that his son's testimony was helpful, it was not sufficient by itself to convincingly corroborate the individual's assertions. A scheduled witness, the individual's supervisor, who was to testify concerning the individual's attendance, reliability and work performance in recent months, did not testify at the Hearing. Another scheduled witness, the individual's treating physician (the veterans hospital doctor) also did not testify.

In my November 16, 2004 letter to the parties, I again noted that it is essential for the individual to provide evidence from knowledgeable witnesses to corroborate his assertion that he has had no episodes of mental illness since December 2002. I stated that his submission of recent medical records and letters from his treating physicians and close relatives would help to provide this corroboration. 5/ However, the only additional evidence received from the individual prior to the December 15, 2004 deadline was the Affidavit of the Evaluating Psychiatrist.

Accordingly, I find that the individual has not demonstrated that he has had no psychotic, manic or depressive episodes since 2002.

D. *The Individual's Level of Risk for Future Bipolar Episodes*

The individual contends that he is very unlikely to have a future manic and/or depressive episode severe enough to affect his judgment and reliability. He asserts that his symptoms are well-

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5/ In this regard, I note that the Hearing record reflects that in addition to his son, the individual maintains close contact with his father and his daughter. TR at 67.

controlled by his medication. He states that any new episodes would be muted in severity and would develop slowly because he is on medication. This assertion is supported by the Affidavit of the Evaluating Psychiatrist. The individual also contends that he can identify the onset of symptoms at an early stage, and can contact the veterans hospital doctor or the veterans clinic at any time to get help. However, the DOE-consultant Psychiatrist testified that there is a significant risk of recurrent episodes of manic or psychotic behavior associated with bipolar disorder. He also stated that it was important for the individual to acknowledge his bipolar condition in order to guard against future episodes.

I find that the individual has not demonstrated that he is at low risk for future of depressive and/or manic bipolar episodes that would negatively affect his judgment and reliability. As discussed above, he has not demonstrated that he has been free of symptoms since 2002. Nor has he corroborated his assertion that he is currently under medical treatment that will permit him to address the onset of depressive and/or manic symptoms on an emergency basis. Finally, the individual clearly does not acknowledge that he suffers from bipolar disorder and has no therapeutic relationship or medical support system specifically addressing his bipolar disorder. Even if his assertions concerning his current support system were substantiated, it is not clear that a system designed to cope with a diagnosis of “major depression with psychotic features” and “post traumatic stress disorder” can also cope with the onset of a bipolar episode. The possibility of a future episode similar to the one that the individual experienced in July 2002, during which his functioning, judgment and reliability were all significantly impaired, poses a security risk to the DOE. I conclude that under the circumstances present in this case, the individual has not demonstrated that the probability of his suffering a future bipolar episode and the consequences of

such an episode do not pose a significant security risk to the DOE. 6/

VI. *CONCLUSION*

For the reasons set forth above, I find that the DOE properly invoked Criterion (h) in suspending the individual's access authorization. After considering all the relevant information, favorable or unfavorable, in a comprehensive and common-sense manner, I find that the evidence and arguments advanced by the individual do not convince me that he has sufficiently mitigated the security concerns accompanying that criterion. In view of Criterion (h) and the record before me, I cannot find that restoring the individual's access authorization would not endanger the common defense and would be clearly consistent with the national interest. It therefore is my conclusion that the individual's access authorization should not be restored. The individual may seek review of this Decision by an Appeal Panel under the regulation set forth at 10 C.F.R. § 710.28.

Kent S. Woods
Hearing Officer
Office of Hearings and Appeals

Date: January 26, 2005

6/ *See Personnel Security Hearing (Case No. TSO-0031)*, 28 DOE ¶ 82,950 (2003) (possibility of relapse was too great for individual with Bipolar Affective Disorder to retain her access authorization); *Personnel Security Hearing (Case No. VSO-0358)*, 28 DOE ¶ 82,755 (2000) (possibility of relapse was too great for individual with Bipolar I Disorder to retain his access authorization); and *Personnel Security Hearing (Case No. VSO-0150)*, 26 DOE ¶ 82,789 (1997) *aff'd Personnel Security Review, Case No. VSA-0150*, 27 DOE ¶ 83,002 (1997) (aff'd OSA 1998) (possibility of relapse was too great to allow an individual with Bipolar I Disorder to retain his access authorization).